MCG Health, Inc.
1120 15th Street
Augusta, Georgia 30912

Patient Name:	PINDER, DORIS M
MRN:	000134507
Birthdate:	[redacted]
Account Number:	0001345078078
Visit Date:	3/18/2008
Discharge date:	3/21/2008
Patient Type:	Inpatient
Location:	6TEL

Discharge

Discharge Summary

MCG Health Inc.

Patient Name:	PINDER, DORIS M
Medical Record #:	000134507
Date Admitted:	03/18/2008
Date Discharged:	03/21/2008
Job #:	45654

PRINCIPAL DIAGNOSES:
1. Third degree heart block secondary to #2.
2. Digoxin toxicity.
3. Acute kidney injury.
4. Coronary artery disease status post PCI to LAD.
5. Paroxysmal atrial fibrillation.
6. Hypertension.
7. Obstructive sleep apnea.
8. Diabetes mellitus.
9. Hypertension.

PRINCIPAL PROCEDURES:
1. Digibind.
2. Transthoracic echocardiogram.
3. EKG.
4. Chest x-ray.
5. Telemetry monitoring.
6. Routine labs.
7. Medical management.

HISTORY OF PRESENT ILLNESS:
This is a 55-year-old African-American female with past medical history significant for recent PCI to the left circumflex in 02/08 at University Hospital, as well as diabetes mellitus, hypertension, CAD, unstable angina, chronic kidney disease and atrial flutter/atrial fibrillation who presented to the ER in third degree heart block with heart rate in the 30s. The patient had a recent PCI secondary to chest pain and ST elevation in the anterior leads. Rate was controlled during that hospitalization with Cardizem and digoxin post PCI. The patient was subsequently discharged on digoxin 0.25 and Taztia

MCG Health, Inc.
1120 15th Street
Augusta, Georgia 30912

Patient Name:	PINDER, DORIS M
MRN:	000134507
Birthdate:	[redacted]
Account Number:	0001345078078
Visit Date:	3/18/2008
Discharge date:	3/21/2008
Patient Type:	Inpatient
Location:	6TEL

her borderline creatinine. Her glyburide was increased from 1.25 p.o. b.i.d. to 2.5 p.o. b.i.d. She was advised to follow up with her primary care physician regarding her diabetes medications.

DISCHARGE MEDICATIONS:
1. Aspirin 81 mg p.o. daily.
2. Lasix 40 mg p.o. daily.
3. Hydralazine 75 mg p.o. t.i.d. .
5. Plavix 75 mg p.o. daily.
6. Coumadin 10 mg p.o. daily.
7. Zaroxolyn 5 mg p.o. daily.
8. Vytorin 10/40 mg p.o. at bedtime.
9. Isordil 60 mg p.o. b.i.d.
10. Labetalol 300 mg p.o. daily.
11. Glyburide 2.5 mg p.o. b.i.d.
12. Benicar 40 mg p.o. daily.

The patient was advised to stop metformin, Digitek, diltiazem and clonidine until following up with her cardiologist.

DISCHARGE INSTRUCTIONS;
1. She was advised to maintain a low-sodium diet.
2. Return to MCG or University Hospital or call 911 should the following symptoms worsen: bradycardia, shortness of breath, or chest pain.
3. Physical activity as tolerated.

DISCHARGE FOLLOW-UP:
The patient was advised to follow up with Dr. Mac Bowman, her cardiologist within one week.

DISCHARGE CONDITION:
She was discharged on 03/21/08, at 11 a.m. in stable condition.

cc: Mac Bowman, M.D.
Department of Cardiology
University Hospital

DT: JB/7575 D: 03/21/2008 T: 03/24/2008

Modified By: Mindy Gentry MD
Date/Time Modified: 04/18/2008 11:19 am

Electronically Signed By: Mindy Gentry MD
Date/Time Signed: 04/18/2008 11:19 am

Printed: 6/2/2009 Printed By: Whittington, Nichole

MCG Health, Inc.
1120 15th Street
Augusta, Georgia 30912

Patient Name:	PINDER, DORIS M
MRN:	000134507
Birthdate:	[redacted]
Account Number:	0001345078078
Visit Date:	3/18/2008
Discharge date:	3/21/2008
Patient Type:	Inpatient
Location:	6TEL

VITAL SIGNS: On admission, temperature 36.1, blood pressure 118/45, pulse 31, respirations 19. O2 91% on 2 liters. GENERAL: Drowsy in mild distress, oriented times three. HEENT: Pupils equal, round and reactive to light. NECK: No JVD, no bruits. CARDIOVASCULAR: Severe bradycardia, S1 and S2. LUNGS: Clear to auscultation bilaterally. ABDOMEN: Obese and nontender, nondistended. Normoactive bowel sounds. EXTREMITIES: No clubbing, cyanosis or edema.

LABORATORY & RADIOLOGIC DATA:
Cardiac catheterization performed at University Hospital from 02/14/08 demonstrated left circumflex to OM 80%, left mai within normal limits, LAD 20 to 30%, RCA distal mild disease. Conclusion: PTCA and drug-eluting stent to the left circumflex. EKG at MCG demonstrated third degree heart block with a rate of 38 and a QT corrected of 327. Chest x-ray showed no acute infiltrate. Echocardiogram demonstrated normal EF with no wall motion abnormalities. Labs at the time of admission showed white blood cell count of 6.5, hemoglobin 9.7, hematocrit 30.2, and platelets of 306,000. PT 20.6, INR 2.6, PTT 32. Sodium 133, potassium 6.6, chloride 103, bicarb 21, BUN 30, creatinine 3.5 up from baseline of 1.5, glucose 316, calcium 8.6. Phosphorus 4.5, magnesium 2, digoxin level of 3.5.

HOSPITAL COURSE:
1. This is a 55-year-old African-American female who presented to the emergency room with severe bradycardia and third degree heart block. At the time of presentation, her digoxin level was 3.5 and she was given two vials of Digibind. The patient's subsequently reverted back into normal sinus rhythm after receiving two vials of Digibind. She was initially started on dopamine drip at 5 mcg/ minute to increase her heart rate and pacer pads were placed as a precaution. However, they were not required. Dopamine drip was titrated off on the afternoon following admission
2. The patient also presented with severe hyperkalemia of 6.6. No EKG changes were noted. She was given insulin D50, bicarb and Kayexalate in the emergency room and on review of her medication records, it appeared that she was taken 160 mEq of potassium outpatient, although this does not appear to be what she was discharged on from her last visit to University Hospital. After receiving Digibind and treatment for hyperkalemia, subsequent BMPs found her potassium within normal limits.
3. Acute kidney injury. The patient presented with a creatinine of 3.5, up from her baseline per University Hospital records of 1.5. This was thought likely to be secondary to a prerenal state as the patient states she has had nausea, vomiting, and diarrhea. FENa was noted to be 9.05% and this was felt to be likely secondary to ATN during her prolonged prerenal state. Her creatinine improved with gentle hydration throughout her hospital course, and at the time of discharge, her creatinine was 1.4, down from her admission creatinine of 3.5.
4. Coronary artery disease, status post recent PCI. The patient was continued on Plavix and aspirin. Her beta blocker and ACE inhibitor were initially held secondary to bradycardia.
5. Hypertension. The patient's hypertension was very difficult to control throughout her initial hospital course. On the evening following her episode of bradycardia, her blood pressure shot up into the 200s/100s. She was started on a nitroglycerin drip at 20 mcg/minute. However, this was titrated all the way up to 130. The patient was reinitiated on hydralazine 50 mg p.o. t.i.d. and Isordil 60 mg p.o. b.i.d. for afterload reduction. Her beta blocker, clonidine, and diltiazem were held secondary to her bradycardia and their interaction with digoxin. She was then started on felodipine 10 mg p.o. daily and hydralazine was titrated up to 75 mg p.o. t.i.d. She was subsequently started back on her labetalol 300 mg p.o. daily. She was advised at the time of discharge not to continue diltiazem, digoxin, or clonidine until follow-up with Dr. Mac Bowman, her cardiologist.
6. Diabetes mellitus: In terms of the patient's diabetes, she was initially started on insulin drip for better glucose control, as well as for her hyperkalemia. She was later changed over to Lantus and NPH regimen. However at the time of discharge, she was discharged back on oral agents. She was advised not to continue her metformin at this time, given

MCG Health, Inc.
1120 15th Street
Augusta, Georgia 30912

Patient Name:	PINDER, DORIS M
MRN:	000134507
Birthdate:	[redacted]
Account Number:	0001345078078
Visit Date:	3/18/2008
Discharge date:	3/21/2008
Patient Type:	Inpatient
Location:	6TEL

for rate control. Recently, the patient states that she had decreased p.o. intake and developed nausea and vomiting times two days. She subsequently had three episodes of syncope the morning of admission and experienced chest pain the morning of admission as well. In the ER, she was noted to have a heart rate in the 30s, as well as potassium of 6.6, creatinine of 3.5, and digoxin level of 3.5. She was given two vials of Digibind in the emergency room. Pacer pads were placed. The patient was given D50, 1 amp of bicarb, insulin and Kayexalate for hyperkalemia.

PAST MEDICAL HISTORY:
1. Coronary artery disease status post PCI to left circumflex.
2. Hypertension.
3. Atrial flutter with RVR.
4. Diabetes mellitus.
5. Stage II chronic kidney disease.
6. Hyperlipidemia.
7. Obstructive sleep apnea.

Past surgical history:
Nephrectomy in 1976.

Review of systems:
Positive for nausea and vomiting, decreased p.o. intake, blurry vision, shortness of breath, chest pain, diarrhea times two days. Otherwise, negative.

Family history:
Hypertension and CAD.

Medications:
1. Digoxin 0.25 mg 1 p.o. daily.
2. Plavix 75 mg p.o. daily.
3. Isordil 60 mg p.o. b.i.d.
4. Glyburide 1.25 mg p.o. b.i.d.
5. Metformin 500 mg p.o. b.i.d.
6. Lasix 40 mg p.o. daily.
7. Labetalol 300 mg p.o. daily.
8. Iron sulfate 325 mg p.o. daily.
9. Vytorin 10/40 p.o. daily.
10. Clonidine 0.2 mg p.o. b.i.d.
11. Benicar 40 mg p.o. at bedtime.
12. Metolazone 5 mg p.o. daily.
13. Taztia, dose unknown.
14. Hydralazine 50 mg p.o. t.i.d.
15. Coumadin 12 mg p.o. daily.
16. KCl 80 mg p.o. b.i.d.

PHYSICAL EXAMINATION: